200% FPL

FAMILY PLANNING AND REPRODUCTIVE HEALTH
DETERMINATION OF CLIENT ELIGIBILITY FOR STATE FUNDED SURGICAL SERVICES
Effective April 1, 2004

Client Name _____ Client ID Number _____

Date of Visit _____ Date of Birth _____ Age _____

Gross Monthly Income _____ Family Size _____

Family Size	1	2	3	4	5	6	7	8	Each Additional Person
Maximum* Monthly Income	**$1,552**	**$2,082**	**$2,612**	**$3,142**	**$3,672**	**$4,202**	**$4,732**	**$5,262**	**$265**

SERVICE CLIENT IS ELIGIBLE FOR _____

FROM _____ **TO** _____

"I am not covered by a private insurance or Title XIX (Public Assistance) plan which covers this service."
"I have been offered a written statement of the results of this eligibility determination."
"I hereby agree that all facts stated above are true and accurate to the best of my knowledge."

_____ _____
Client's Signature Date Witness' Signature Date

CLIENT ELIGIBILITY DETERMINATION FOR NEW SERVICE WHEN FAMILY SIZE AND INCOME HAVE NOT CHANGED

SERVICE CLIENT IS ELIGIBLE FOR _____

ELIGIBILITY PERIOD FROM _____ **TO** _____

"My family size and income have not changed since the last eligibility determination."

_____ _____
Client's Signature Date Witness' Signature Date

Eligibility for state funded services does not guarantee/ensure that services will be provided with those funds. Provision of service with state funds is dependent upon availability of funds.

*** Instructions for computing monthly income and completing this form are on the back.**